MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

T 04333

Reg. Dist. No. 355

1. PLACE OF DEATH:
County Worcester.
City or town Berlin.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Berlin.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Daniel Wells Babcock.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Nancy May Babcock.
6.(c) If alive, give age: 67 years
7. Birth date of deceased (mo., day, yr.): May 15, 1864

8. AGE: Years	Months	Days	If less than one day
80	11	13	...hrs. ...min.

9. Birthplace: Danville N.Y. (Town, county, and state)
10. Usual occupation: Newspaperman.
11. Industry or business
FATHER 12. Name: Elisha Babcock
FATHER 13. Birthplace: Danville N.Y.
MOTHER 14. Maiden name: Eva Harter.
MOTHER 15. Birthplace: Danville N.Y.
16. Informant: Mrs. D.W. Babcock
Address: Berlin Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/2/45 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Berlin Md
18. Funeral director: Emma A. Burbage
Address: Berlin Md.
19. 5-2-45 Helen F. Hayward Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 19 45 at 2:00 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 43 to Apr 30 19 45
and that I last saw him alive on April 29 19 45

Immediate cause of death	DURATION
Coronary Occlusion	sudden
Due to: Generalized Arteriosclerosis	15 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L Shiveall M. D. or other
Address: Berlin, Md Date signed 5/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1944
1864
80

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-C

04334

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County Worcester
City or town Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Henry Barr

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	D. K.

6.(b) Name of husband or wife (?)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) D K.

8. AGE: Years 42 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Southampton Co. Va
(Town, county, and state)

10. Usual occupation Farmer Mill yard

11. Industry or business

FATHER
12. Name D K.
13. Birthplace D K.

MOTHER
14. Maiden name D K.
15. Birthplace D K.

16. Informant Acquaintance as Mill Yard
Address Travis's Mill - Beaver Dam

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5-1945 (month) (day) (year)
Cemetery or crematory Hall's Hill
Location Rural Pocomoke
18. Funeral director Margaretta L. Watson
Address Pocomoke City Md.

19. April 5 19 45 (Date rec'd by registrar) Annie E. Pitts Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 4th 1945, at 4.9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19.. and that I last saw h.. alive on April 4 1945

Immediate cause of death Probably Cardiac Collapse — DURATION

Due to

Due to

Other conditions Heart trouble — Years

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE P. E. Jarboe M.D.
M. D. or other
Address Pocomoke City Md. Date signed 4/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-C)

CERTIFICATE OF DEATH

04335

Reg. Dist. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 90 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Worcester

City or town: Berlin R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Ironsburg.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Sarah M. Bassett.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow.

6.(b) Name of husband or wife: Isaac T. Bassett.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 4, 1854.

8. AGE: Years	Months	Days	If less than one day
90	6	18	hrs. min.

9. Birthplace: Berlin Worcester Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business:

FATHER
12. Name: William Gray.
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Maria Coulbourn.
15. Birthplace: Maryland.

16. Informant: Mrs. Fred Hastings.
Address: Berlin, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/25/45 (month) (day) (year)

Cemetery or crematory: Evergreen.

Location: Berlin, Md.

18. Funeral director: Anna A. Burbage.

Address: Berlin, Md.

19. 4-25- 1945 (Date rec'd by registrar) Helen E. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 22 1945, at 5 Aug

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Due to Chr. Myocarditis	
Due to Chr. Nephritis	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Chas. R. Lowe M. D. or other

Address: Berlin, Md. Date signed 4-27-45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(T)

VS A15

(M)

04336

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 60 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Francis Noah Brittingham | **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married.

6.(b) Name of husband or wife Jennie Brittingham
6.(c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) Feb. 21, 1885

8. AGE: Years	Months	Days	If less than one day
60	1	25	hrs. min.

9. Birthplace Md (Town, county, and state)
10. Usual occupation Farmer.
11. Industry or business
FATHER 12. Name Noah Brittingham.
13. Birthplace Maryland.
MOTHER 14. Maiden name Isabel Timmons
15. Birthplace Maryland
16. Informant Mrs. Jennie Brittingham
Address Berlin Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/18/45 (mouth) (day) (year)
Cemetery or crematory Riverside.
Location Berlin Md R.F.D.
18. Funeral director Amos A. Bunbage
Address Berlin Md.
19. 4-18 (Date rec'd by registrar) 1945 Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 1945, at 6 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pulmonary T.B.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Chas R. Law M.D. M. D. or other
Address Berlin Md. Date signed 4-17-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04337

Reg. Dist. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 Years.

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles P. Council

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) April 7, 1861

8. AGE: Years	Months	Days	If less than one day
84	0	6	... hrs. ... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business —

FATHER — 12. Name: Charles P. Council Sr.

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Unknown

15. Birthplace: "

16. Informant: Mrs. Willie Walters

Address: Pocomoke Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15 1945 (month) (day) (year)

Cemetery or crematory: Baptist Cemetery

Location: Pocomoke Md.

18. Funeral director: Margaretta Funeral Home

Address: Pocomoke Md.

19. April 14 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 1945, at 2,30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1945, to April 13 1945

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Contention	1wk
Due to: Carcinoma of Uterus	?
Due to:	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: J. M. Melvin M. D. or —

Address: Pocomoke City Md. Date signed 4/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1951

CERTIFICATE OF DEATH

04338

Reg. Dist. No. 350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Worcester

City or town: RURAL, Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 3 mo. 19 da.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: RURAL, Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt. #2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Emma Dennis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 16, 1943

8. AGE: Years	Months	Days	If less than one day
1	3	19	..... hrs. ..... min.

9. Birthplace: RURAL, Pocomoke-Worcester-Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Phillip Dennis

13. Birthplace: Pocomoke City, Md Rt. 2 #

MOTHER — 14. Maiden name: Josephine Schoolfield

15. Birthplace: Pocomoke City, Md. Rt. 2 #

16. Informant: Phillip Dennis

Address: Pocomoke City, Md. Rt. 2 #

17. Burial (Burial, cremation, or removal. Which?) Date thereof Apr. 6, 1945 (month) (day) (year)

Cemetery or crematory: St. James Cemetery

Location: Pocomoke City, Md. Rt 2 #

18. Funeral director: H. Harvey Bradshaw

Address: Pocomoke City, Maryland

19. April 6, 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 5, 1945, at 5 A M

I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h[illegible] alive on April 4 — 5 — 1945

Immediate cause of death	DURATION
Probably (asphyxia from food in pocket)	Few minutes
Due to [illegible]	
Due to [illegible]	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: None made.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. E. Gentzler M.D.

M. D. or other

Address: Pocomoke City Md Date signed 4/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

04339

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Savannah O. Durham

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George Durham
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): January 16 - 1885

8. AGE: Years	Months	Days	If less than one day
60	x	25	hrs. min.

9. Birthplace: Pocomoke Worcester Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER
12. Name: William T. Cutler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Graham Watson
15. Birthplace: Maryland

16. Informant: Mrs Earl Matthews
Address: Pocomoke City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15-1945 (month) (day) (year)
Cemetery or crematory: Cutler Cemetery
Location: Rural Pocomoke City Md.

16. Funeral director: Margarette S. Watson
Address: Pocomoke City Md.

19. April 14 1945 Anne E. Potter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1945 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945, to April 11 1945
and that I last saw h[illegible] alive on April 11 1945

Immediate cause of death	DURATION
Cancer of Stomach	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C E Cutler M. D. ~~or other~~
Address: [illegible] Date signed 4-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47-2

CERTIFICATE OF DEATH

04341

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill Rural #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 53 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill Rural #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: James Ennis

3. (b) Social Security Number: 212-16-1930

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Annie Ennis
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 20 - 1891

8. AGE:

Years	Months	Days	If less than one day
53	5	9	..... hrs. ..... min.

9. Birthplace: Snow Hill Worcester Md
(Town, county, and state)
10. Usual occupation: Labor
11. Industry or business: Canning Factory
FATHER 12. Name: Unknown
13. Birthplace: "
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
16. Informant: Joseph Fisher
Address: Snow Hill, Md Rural #1
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 1 45 (month) (day) (year)
Cemetery or crematory: M.E. Wesley
Location: Snow Hill, Md
19. Funeral director: Heame & Dennis
Address: Snow Hill, Md
19. 4/30 45 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 29 19 45 at 5 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3/15/45 19 to 4/29/45 19 and that I last saw h... alive on 4/29/45 19

Immediate cause of death	DURATION
Cancer of Pleura	2 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Saul Cohen M.D. M. D. or other
Address: Snow Hill Md Date signed: 4/30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04341

CERTIFICATE OF DEATH

Reg. Dist. No. 35 1

1. PLACE OF DEATH:
County Worcester
City or town Snow Hill (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?
WITHIN CORPORATE LIMITS OF

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Worcester
City or town Snow Hill (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war World War I

3.(a) FULL NAME Clarence W. Harmon

3.(b) Social Security Number 218-10-0435

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 7 — 1897
8. AGE: Years 47 | Months 10 | Days 4 | If less than one day ..... hrs. ..... min.
9. Birthplace: Girdletree Worcester Md (Town, county, and state)
10. Usual occupation: Tailor
11. Industry or business: Canning Factory
12. Name of FATHER: Norris Harmon
13. Birthplace of FATHER: Maryland
14. Maiden name of MOTHER: Ellen Bowley
15. Birthplace of MOTHER: Maryland
16. Informant: Priscilla V. Waters
Address: Snow Hill, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof April 15 45 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Girdletree, Md.
18. Funeral director: Pearce & Timmons
Address: Snow Hill, Md.
19. 4/17 45 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 11 19 45, at 4:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29 19 44, to April 11 19 45 and that I last saw h.. alive on April 10 19 45

	DURATION
Immediate cause of death: Acute Pulmonary Edema	1 day
Due to: Cardiac failure	1 year
Due to: Syphilitic Aortitis	?
Other conditions: Anasarca	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Robert L. LaMar, M.D. M. D. or other
Address Snow Hill Date signed 4-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04342

Reg. Diat. No. 350

1. PLACE OF DEATH:

County Worcester

City or town Beaver Dam

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Beaver Dam

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Wm. Frank Hart

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

B.(b) Name of husband or wife Vina Hart

6.(c) If alive, give age 80 years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 82 | Months Not known | Days not known | If less than one day ..... hrs. ..... min.

9. Birthplace Acco. Co. Va.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name Wm. C. Hart

13. Birthplace Acco. Co. Va

MOTHER

14. Maiden name Sarah Wilkerson

15. Birthplace Acco. Co Va

16. Informant Mrs. Vina Hart

Address Roanoke R F D

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 1 1945 (month) (day) (year)

Cemetery or crematory Wilsons

Location New Church, Va

18. Funeral director W. A. Shields

Address New Church Va

19. May 1 1945 Anne E. White

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 29 1945 at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1945 to April 29 1945

and that I last saw him alive on April 26 1945

Immediate cause of death	DURATION
Myocardial degeneration	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. [illegible] M. D. or other

Address [illegible] Date signed 4-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Miss Harriett Johnson
Phone 1524

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04343

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:
County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Isaac J. Henry

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife Hester Henry.
6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1871

8. AGE: Years	Months	Days	If less than one day
73	4	11	hrs. min.

9. Birthplace Berlin Wor Co. Md.
(Town, county, and state)
10. Usual occupation Brick mason.
11. Industry or business

FATHER
12. Name Isaac C. Henry
13. Birthplace Berlin Md.

MOTHER
14. Maiden name William Anna Morris
15. Birthplace Berlin Md.

16. Informant Mrs. Isaac C. Henry
Address Berlin Md

17. Burial Date thereof 4/6/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Pauls.
Location Berlin Md

18. Funeral director Franklin B. Hill.
Address Salisbury Md

19. 4-6- 1945 Helen I. Hayward
(Date rec'd by registrar) registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 45 at 1130A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Chr. Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas R. Lowe M. D. or other
Address Berlin Md. Date signed 4-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (946)

CERTIFICATE OF DEATH

04345

Reg. Dist. No. 355

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

1. PLACE OF DEATH:
County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55
Hospital, institution, or street address where death occurred: ✓
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Elizabeth Whaley Keas

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John T. Keas.
6.(c) If alive, give age: 77 years
7. Birth date of deceased (mo., day, yr.): Aug 7, 1863

8. AGE: Years: 81 Months: 8 Days: 3 If less than one day: ... hrs. ... min.

9. Birthplace: Whaleyville, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Housework.

FATHER
12. Name: Peter Whaley.
13. Birthplace: Md.

MOTHER
14. Maiden name: Kittie Timmons
15. Birthplace: Md.

16. Informant: John T. Keas.
Address: Berlin Md.

17. Burial, cremation, or removal. Which? Burial. Date thereof: April 11 1945 (month) (day) (year)
Cemetery or crematory: Whaley Cemetery
Location: Whaleyville Md.
18. Funeral director: M. Pasha Watson
Address: Selbyville, Del.

19. 4-11- 1945 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 10 1945 at 12:30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 1945, to day of death.
and that I last saw her alive on April 3, 1945
Immediate cause of death: Angina pectoris

DURATION
2 yrs.

Due to:
Due to:
Other conditions: Hypertension. Arteriosclerosis.
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Frank K. Lewis M. D.
M. D. or other
Address: Willards Md. Date signed: 4-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T04345

Reg. Dist. No. 350

1. PLACE OF DEATH:

County: Worcester

City or town: Pocomoke city, md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs.

Hospital, Institution, or street address where death occurred: ✓

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: walnut
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mary Catherine Payne

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Thomas J. Payne

6.(c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.): September 12, 1866

8. AGE: Years	Months	Days	If less than one day
78	7	18	...hrs. ...min.

8. Birthplace: Pocomoke city, Worcester, md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: John J. Reddew
13. Birthplace: md.

MOTHER
14. Maiden name: Sallie A. Tann
15. Birthplace: md.

16. Informant: Thomas J. Payne
Address: Pocomoke city, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 3, 1945 (month) (day) (year)
Cemetery or crematory: Goodwill
Location: Pocomoke city, Rural

18. Funeral director: Margarette A. Watson
Address: Pocomoke city, md.

19. May 2, 1945 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30, 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23, 1945, to April 30, 1945
and that I last saw h... alive on April 30, 1945

Immediate cause of death	DURATION
Coronary Clot	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: ... M. D. or other

Address: ... Date signed 5-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04346

CERTIFICATE OF DEATH

Reg. Diat. No. 355

1. PLACE OF DEATH:

County: WORCESTER.

City or town: BERLIN R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 YEARS

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MD. County: WORCESTER.

City or town: BERLIN R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: DAVID HENRY PITTS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COLORED	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): DEC. 25, 1925

8. AGE:	Years	Months	Days	If less than one day
	19	3	8	..... hrs. ..... min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: LABORER.

11. Industry or business

FATHER — 12. Name: EDWARD PITTS

FATHER — 13. Birthplace: MARYLAND

MOTHER — 14. Maiden name: ANNIE MORRIS.

MOTHER — 15. Birthplace: MARYLAND.

18. Informant: EDWARD PITTS

Address: BERLIN, MD R.F.D.

17. (Burial, cremation, or removal. Which?) BURIAL Date thereof (month) 4 (day) 5 (year) 45

Cemetery or crematory: ST. PAULS

Location: BERLIN, MD.

18. Funeral director: Franklin B. Kiel

Address: Salisbury Md.

19. (Date rec'd by registrar) 4-5-45 Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 1945 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pulmonary TB	
Due to: Not in Evidence	
Due to: a Sanatorium case.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Chas R. Farr M. D. or other

Address: Pittsburg Md. Date signed 4-5-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

04347

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County Worcester

City or town Berlin R. F. D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Berlin R I D
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Albert Purnell.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife Ida Purnell

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 56			hrs. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name John Purnell.

13. Birthplace Maryland.

MOTHER 14. Maiden name Comfort Hudson.

15. Birthplace Maryland.

16. Informant Ida Purnell.

Address Berlin Md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/18/45 (month) (day) (year)

Cemetery or crematory St. Pauls (Col.)

Location Berlin, Md.

18. Funeral director Duma A. Burbage

Address Berlin Md

19. 4-18 19 45 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 16 19 45 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 13 19 45 to April 16 19 45

and that I last saw him alive on April 13 19 45

Immediate cause of death	DURATION
Uremia	
Due to Nephritis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford E. Lokett M. D. or other

Address Berlin Md Date signed 4-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

04348

Reg. Dist. No. 351

1. PLACE OF DEATH:
County Worcester
City or town Snow Hill Rural #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Snow Hill Rural #3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME Alfred A. Shockley

3. (b) Social Security Number Withheld Laws Enacted July

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Rhoda Shockley
6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Aug. 16 1882

8. AGE: Years 63 | Months 6 | Days 18 | If less than one day ... hrs. ... min.

9. Birthplace Snow Hill Worcester Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Selby Gray
13. Birthplace Maryland

MOTHER 14. Maiden name Unknown
15. Birthplace

16. Informant Clifton A. Shockley
Address Snow Hill, Md Rural #2

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 4 45 (month) (day) (year)
Cemetery or crematory Friendship
Location Snow Hill Md Rural

18. Funeral director Adams & Dennis
Address Snow Hill Md

19. 4/4/45 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 19 45, at 10 46 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 19 45, to April 4 19 45
and that I last saw h... alive on April 3 19 45

Immediate cause of death	DURATION
Respiratory paralysis	5 min
Due to Cerebral Vascular accident	4 days
Due to Hypertensive Cardiovascular renal disease	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert L. La Mar M.D.
M. D. or other
Address Snow Hill Md Date signed 4/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 04349

Reg. Diat. No. 357

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill, Rural #1 (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill, MD Rural #1 (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Frances M. Short

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Jessie W. Short
6.(c) If alive, give age: 30 years
7. Birth date of deceased (mo., day, yr.): Sept. 16, 1913

8. AGE: Years	Months	Days	If less than one day
31	7	14	hrs. min.

8. Birthplace: Marshallton, Delaware (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: John Dickil
FATHER 13. Birthplace: Delaware
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: "
16. Informant: Mrs. Jessie W. Short
Address: Snow Hill, MD Rural #1
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 3 45 (month) (day) (year)
Cemetery or crematory: Evergreen
Location: Berlin, MD
18. Funeral director: Deane & Dennis
Address: Snow Hill, MD
19. 5/1 45 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 30 1945, at 1 15 P. M
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from April 21 1945, to April 30 1945 and that I last saw h.r. alive on April 29 1945

Immediate cause of death	DURATION
Dry gangrene of left leg	Unknown
Due to: M. Heart	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John L. Riley Jr. M. D. M. D. or other
Address: Snow Hill, Md Date signed: 5/1/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 840

04350

CERTIFICATE OF DEATH

Reg. Diat. No. 355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Worcester.
City or town Berlin R. F. D.
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Worcester.
City or town Berlin R F D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Everett LeRoy Smith Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single.

B.(b) Name of husband or wife
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1941

8. AGE:

Years	Months	Days	If less than one day
3	8	28	hrs. min.

9. Birthplace Berlin Wor Co Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Everett LeRoy Smith Sr.
13. Birthplace Berlin, Md.

MOTHER
14. Maiden name Hester Fisher.
15. Birthplace Berlin Md.

16. Informant Webster Smith
Address Berlin Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/5/45 (month) (day) (year)
Cemetery or crematory St. Pauls.
Location Berlin Md.

18. Funeral director Franklin B. Veil.
Address Salisbury Md

19. 4-5 1945 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 19 45, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 45 to Apr. 3 19 45 and that I last saw h. liv. alive on Apr. 3 19 45

Immediate cause of death	DURATION
Spasm	
Congenital mental	Life
condition not	
Due to definitely diagnosed	
at Johns Hopkins	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clifford E. Abbott M. D. or other
Address Berlin Md Date signed 4-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04351

Reg. Diat. No. 855

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Berlin.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Emily Smith.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1864

8. AGE: Years	Months	Days	If less than one day
80	4	11	..... hrs. ..... min.

8. Birthplace: Somerset Worcester Co. Md.

(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER 12. Name: Hampton H. Smith.

FATHER 13. Birthplace: Maryland.

MOTHER 14. Maiden name: Emily Simms.

MOTHER 15. Birthplace: Maryland.

16. Informant: Mrs. Lucie Collins

Address: Berlin Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/11/45 (month) (day) (year)

Cemetery or crematory: Evergreen.

Location: Berlin, Md.

18. Funeral director: Franklin B. Reid

Address: Salisbury Md.

19. 4-11- 1945 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 8 1945 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 15, 1945, to April 8, 1945 and that I last saw h.m alive on April 7, 1945

Immediate cause of death	DURATION
Myocarditis - Chronic	3 yrs ?
Due to	
Due to	
Other conditions Adeno-carcinoma right mammary gland.	

(Incinde pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Frank P. Lewis M.D.

M. D. or other

Address: Willards Md. Date signed 4/11/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92

CERTIFICATE OF DEATH

04352 351

Reg. Dist. No.

WITHIN CORPORATE LIMITS OF

1. PLACE OF DEATH:

County Worcester

City or town Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Lucy K. Stagg

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

8.(b) Name of husband or wife —

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 28 1909

8. AGE:

Years	Months	Days	If less than one day
36	1	21	hrs. ..... min.

9. Birthplace Snow Hill Md

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business —

FATHER

12. Name Wm R. Stagg

13. Birthplace New Jersey

MOTHER

14. Maiden name Laura Catherine Bailey

15. Birthplace Snow Hill, Md

18. Informant Mrs R. N. Stagg

Address Snow Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 21 45 (month) (day) (year)

Cemetery or crematory Episcopal

Location Snow Hill, Md

18. Funeral director Deane & Timmis

Address Snow Hill, Md

19. 4/19/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 18 1945, at 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19.., to — 19..

and that I last saw h... alive on — 19..

Immediate cause of death	DURATION
(a) Mitral regurgitation	
(b) Heart	30 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Lee A. Tilden Dr. Med. Examr

M. D. or other

Address Snow Hill Md Date signed 4/18/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

04353

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH 159

County Worcester Registration Dist. No. 350

Village or City Pocomoke No. 512 Pine St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. if of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Dan Tull

(a) Residence: No. ... St., ... Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	W	M

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ...

6. DATE OF BIRTH (month, day, and year) October 22

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
				7

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. none

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. ...

10. Date deceased last worked at this occupation (month and year) none

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) Pocomoke City Md.
(State or country)

FATHER

13. NAME Dan Tull

14. BIRTHPLACE (city or town) Pocomoke City Md.
(State or country)

MOTHER

15. MAIDEN NAME Wanda Handy

16. BIRTHPLACE (city or town) Pocomoke City Md.
(State or country)

17. INFORMANT Dan Tull
(Address) Pocomoke City Md.

18. BURIAL, CREMATION, OR REMOVAL
Place Hall's Hill Cem. Date April 24, 1945

19. UNDERTAKER Ira Duffy (Father)
(Address) Pocomoke City Md.

20. FILED April 24, 1945 Annie E. White
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April 23, 1945
(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from ... 19... to ... 19...

I last saw him alive on April 23, 1945; death is said to have occurred on the date stated above, at ... P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Pneumonia both	
Other Contributory Causes of importance:	

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of Injury ..., 19...

Where did injury occur? ...
(Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ...

Nature of injury ...

24. Was disoase or injury in any way related to occupation of deceased? ...

If so, specify ...

(Signed) ... M. D.

(Address) ...

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64a)

CERTIFICATE OF DEATH

04354

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: Newark Rural #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 62 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Newark Rural #1
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: 70

3. (a) FULL NAME: Stanley C. Tull

3. (b) Social Security Number: U.S. Coast Guard Fort Miles Lewes Delaware

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lucy O. Tull
6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Dec 13 - 1882

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
62	4	8		

9. Birthplace: Newark Md (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
FATHER — 12. Name: J. Frank Tull
FATHER — 13. Birthplace: Newark Md
MOTHER — 14. Maiden name: Lillie Jones
MOTHER — 15. Birthplace: Newark Md
16. Informant: Mrs. Stanley Tull
Address: Newark Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 23/45 (month) (day) (year)
Cemetery or crematory: Bowen
Location: Newark, Md.
18. Funeral director: Deane S. Bowen
Address: Snow Hill Md
19. 4/23/45 (Date rec'd by registrar) 19 45 R. Ray Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 19 45, at 6.30 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ~ 19 ~, to ~ 19 ~
and that I last saw h alive on ~ 19 ~

Immediate cause of death	DURATION
Strangulation due to	
Lawsing — Suicide	—
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: Apr. 21 45
Where did injury occur? Newark (City or town) Worcester (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Lawsing Injured at work? No

23. SIGNATURE: Geo. L. Riley Dep. Med Exam. M. D. or other
Address: Snow Hill Md Date signed: 4/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15